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MONTHLY HEALTH REPORT

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VOL 1 NO 5

MILITARY DISTRICT OF WASHINGTON

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MONTHLY HEALTH REPORT

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HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON
The Pentagon, Washington 25, D. C.

OCTOBER 1948
Vol. 1 No. 5

U.S. Army. Military District of Washington

INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army and Department of the Air Force personnel in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest.

Contributions, as well as suggested topics for discussion, are solicited from Medical Department officers in the field.

FLOYD V. KILGORE
Colonel, MC
Surgeon

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GENERAL COMMENT

Generally, the health of the command has continued to be satisfactory. The non effective rate for the current period is 13.20 as compared with 14.62 for August. The venereal disease and respiratory disease rates have both shown a gratifying reduction.

Unless otherwise indicated, references to diseases and injuries in this publication apply to all Class I and II installations exclusive of Walter Reed General Hospital. Rates are calculated on the basis of a thousand mean strength per year.

In consideration of the present mode of operation of the Army Medical Department whereby Army and/or Air Force personnel may be receiving medical treatment at either type department installation, differential health statistics for Air Force and Army should be evaluated as an overall index of the medical sections of the reporting unit.

Admissions for all causes decreased from a rate of 399.7 for 563 admissions in August to a 301.6 rate for 442 admissions for September. All stations except Vint Hill Farms Station contributed to this lower rate. At that last mentioned installation, a rate of 463.8 was reported as compared with 446.2 for August 1948. The initial report from the Washington QM Depot Dispensary indicates a rate of 1444.4 for 1 admission from a strength of 9 personnel. However, rates computed on the basis of posts having a strength of less than 500 should be read with tolerance in view of the low variable allowance factor.

A slight increase in the rate for injury cases was reported. A September rate of 31.4 is compared with 29.8 for the previous period. A total of 46 cases were reported for September against 42 cases for August. Fort Belvoir continued to show a decrease in the number of injury admissions with the rate of 20.7 for the present month 12.2 points below the rate reported in August.

Psychiatric admissions during September dropped to less than half of the number reported in August with a resultant rate of 8.2 as compared with 17.8. The total cases reported for September and August were 12 and 25 respectively.

During the current month, 1 death resulting from disease was reported by Fort Belvoir.

COMMUNICABLE DISEASE

No cases of pneumonia were reported during September.

Incidence of influenza reflected a decline to a rate of 3.4 for 5 cases as compared with 10 cases and a rate of 7.1 for August.

Common respiratory diseases also decreased with a rate of 47.1 for 69 admissions against a rate of 65.3 and 92 cases in the preceding month. Lower incidence at the General Dispensary and Fort Belvoir accounted for this drop.

The only case of hepatitis, reported by the General Dispensary during September, resulted in a MDW rate of .7.

A rate of 1.4 for diarrheal disease resulted from 2 cases reported by Fort McNair in September.

Measles, mumps, rheumatic fever, tuberculosis and other communicable diseases reflected no appreciable change.

* * * * * * * * * * * * * * *

Pertinent Statistical tables may be found on pages 2 and 4.

* * * * * * * * * * * * * * *

GENERAL DATA
4 Week period Ending 24 September 48
(Data from WD AGO Form 8-122)

STATION	MEAN STRENGTH			ADMISSIONS						Non-Effective Rate	Number of CDD's	Number of Deaths
				All Causes		Disease		Injuries				
	Total	White	Negro	Cases	Rates	Cases	Rates	Cases	Rates			
Arlington Hall	716	716	0	12	217.9	11	199.7	1	18.2	0.65	0	0
Fort Belvoir	7,541	6,497	1,044	169	291.3	157	270.6	12	20.7	24.71	8	1
Fort McNair	857	762	95	19	288.2	17	257.9	2	30.3	1.71	0	0
Fort Myer (North Post)	1,464	1,299	165	109	967.9	96	852.5	13	115.4	36.01	0	0
Fort Myer (South Post)	1,873	1,873	0	18	124.9	18	124.9	0	-	0.17	0	0
General Dispensary, USA	5,642	5,615	27	80	184.3	73	168.2	7	16.1	1.45	0	0
Vint Hill Farms	953	953	0	34	463.8	24	327.4	10	136.4	2.10	0	0
Washington QM Depot	9	9	0	1	1,444.4	0	-	1	1,444.4	11.90	0	0
Total Mil Dist of Wash	19,055	17,724	1,331	442	301.6	396	270.2	46	31.4	13.20	8	1
Army Medical Center	2,525	2,219	306	119	612.7	108	556.1	11	56.6	477.28	70	7
Total Dept/Army Units	21,580	19,943	1,637	561	337.9	504	303.6	57	34.3	67.50	78	8
CLASS III UNITS												
Andrews Air Force Base	3,510	3,390	120	61	225.9	51	188.9	10	37.0	2.72	0	0
Bolling Air Force Base	5,159	5,159	0	103	259.6	95	239.4	8	20.2	8.01	0	0
Wash Nat'l Airport	1,579	1,579	0	25	205.8	22	181.1	3	24.7	0.77	0	0
Total Dept/Air Force Units	10,248	10,128	120	189	239.7	168	213.1	21	26.6	5.08	0	0
Consolidated Total	31,828	30,071	1,757	750	306.3	672	274.4	78	31.9	47.40	78	8

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
4 Week Period Ending 24 September 1948
(Data From WD AGO Form 8-122)

STATION	Common Respiratory Diseases	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Psychiatric Disease
Arlington Hall	36.3	-	-	-	-	-	-	-	-	-	-	-	-
Fort Belvoir	17.2	-	-	-	-	-	-	-	1-7	-	-	-	17.2
Fort McNair	15.2	-	-	-	-	-	-	-	-	30.3	-	-	-
Fort Myer (North Post)	142.1	-	-	-	-	-	-	-	-	-	-	-	-
Fort Myer (South Post)	20.8	-	-	-	-	-	-	-	-	-	-	-	-
General Dispensary, USA	43.8	-	-	11.5	-	4.6	-	-	-	-	2.3	-	4.6
Vint Hill Farms	245.5	-	-	-	-	-	-	-	-	-	-	-	-
Washington QM Depot	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Mil Dist of Wash	47.1	-	-	3.4	-	1.4	-	-	0.7	1.4	0.7	-	8.2
Army Medical Center	5.2	10.3	5.2	-	-	10.3	-	-	5.2	-	10.3	-	-
Total Dept/Army Units	42.2	1.2	0.60	3.0	-	2.4	-	-	1.2	1.2	1.8	-	7.2
CLASS III UNITS													
Andrews Air Force Base	51.8	-	-	-	-	-	-	-	-	-	-	-	-
Bolling Air Force Base	10.1	-	-	5.0	-	2.5	-	-	-	-	5.0	2.5	22.7
Wash Nat'l Airport	49.4	-	-	-	-	-	-	-	-	-	-	-	-
Total Dept/Air Force Units	30.4	-	-	2.5	-	1.3	-	-	-	-	2.5	1.3	11.4
Consolidated Total	38.4	0.8	0.4	2.9	-	2.0	-	-	0.8	0.8	2.0	0.4	8.6

VENEREAL DISEASE: ARMY TROOPS

The Venereal Disease Rate for Army troops within the Military District of Washington has shown an appreciable decrease from a rate of 32.13 per 1000 per year in August to 18.42 for the current report period. A total of 27 cases were reported for the month as compared with 52 cases for the previous period. This considerably lower rate is attributable to the reduction in the number of cases of venereal disease among Negro personnel. For the present month only 7 cases were reported for a rate of 68.37 as against 32 cases and a rate of 248.38 for August. The rate of 14.67 for white personnel, however, reflects an increase over the August rate of 13.43.

The total 39.65 rate for Fort Belvoir for September is an improvement over the August rate of 64.03 but the white rate has shown an increase to 32.01 cases per 1000 per year from 17.19 for August. A reduced rate was reported by Fort McNair with a current rate of 15.17 compared with 64.03 for the previous period.

VENEREAL DISEASE: AIR FORCE TROOPS

A reduction in the incidence of Venereal disease was also reported among Air Force personnel. The current rate of 19.03 is over 2 points less than the 21.41 reported in August. Among Negro personnel, 4 cases of Venereal disease were reported from a strength of 120 troops for a rate of 433.33.

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Pertinent statistical tables and charts may be found on pages 4, 5, 6 and 7

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The term "Chargeable Cases" as used in this report refers to those occurring among individuals assigned or attached to the reporting station at the time of the diagnosis.

NEW VENEREAL DISEASE CASES - EXCL EPTS - SEPTEMBER AND AUGUST *

STATION	Rate per 1000 per Year SEPTEMBER 48	AUGUST 48
Arlington Hall	-	19.40
Fort Belvoir	39.65	64.03
Fort McNair	15.17	63.88
Fort Myer (North Post)	8.88	9.24
Fort Myer (South Post)	6.94	28.14
General Dispensary	2.3	-
Vint Hill Farms Station	-	12.95
Washington QM Depot	-	-
Total Military District of Washington	18.42	32.55
Army Medical Center	30.89	29.26
Total Dept/Army Units, MDW	19.88	32.13
CLASS III UNITS		
Andrews Air Force Base	22.22	18.11
Bolling Air Force Base	22.68	30.40
Washington Nat'l Airport	-	-
Total Class III Units	19.03	21.41
CONSOLIDATED TOTAL	19.61	28.60

* Includes all cases reported on Statistical Health Reports WD AGO Form 8-122.

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURIES

MDW RATES PER 1000 TROOPS PER YEAR

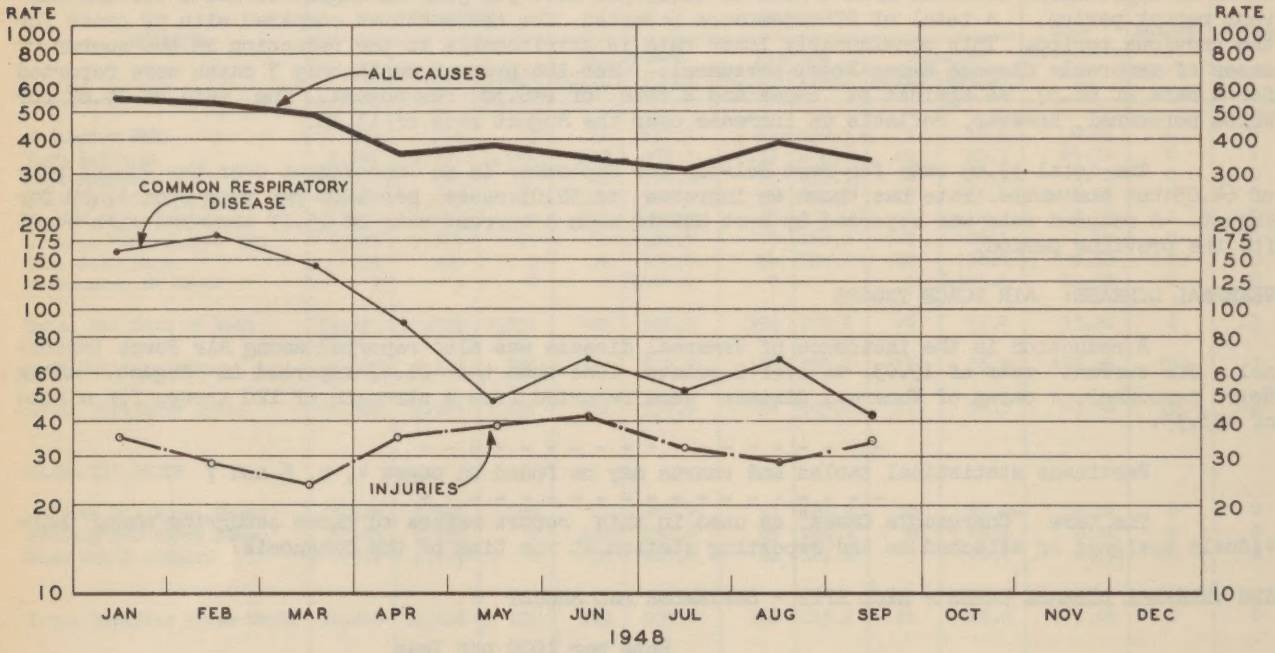
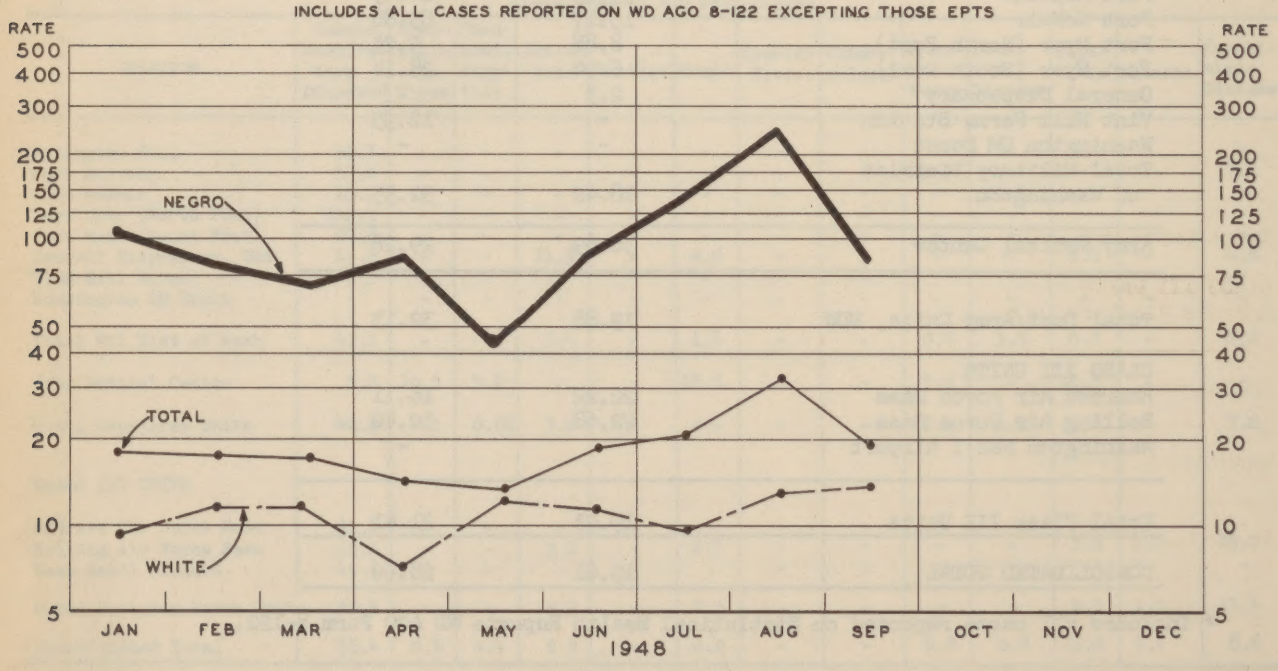


CHART 2

ADMISSION RATES BY MONTH, VENEREAL DISEASES, MIL. DIST. OF WASH. 1948

RATES PER 1000 TROOPS PER YEAR

INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT
For the Four Week Period Ending 24 September 1948
(Data from WD AGO 8-122)(Chargeable Cases)

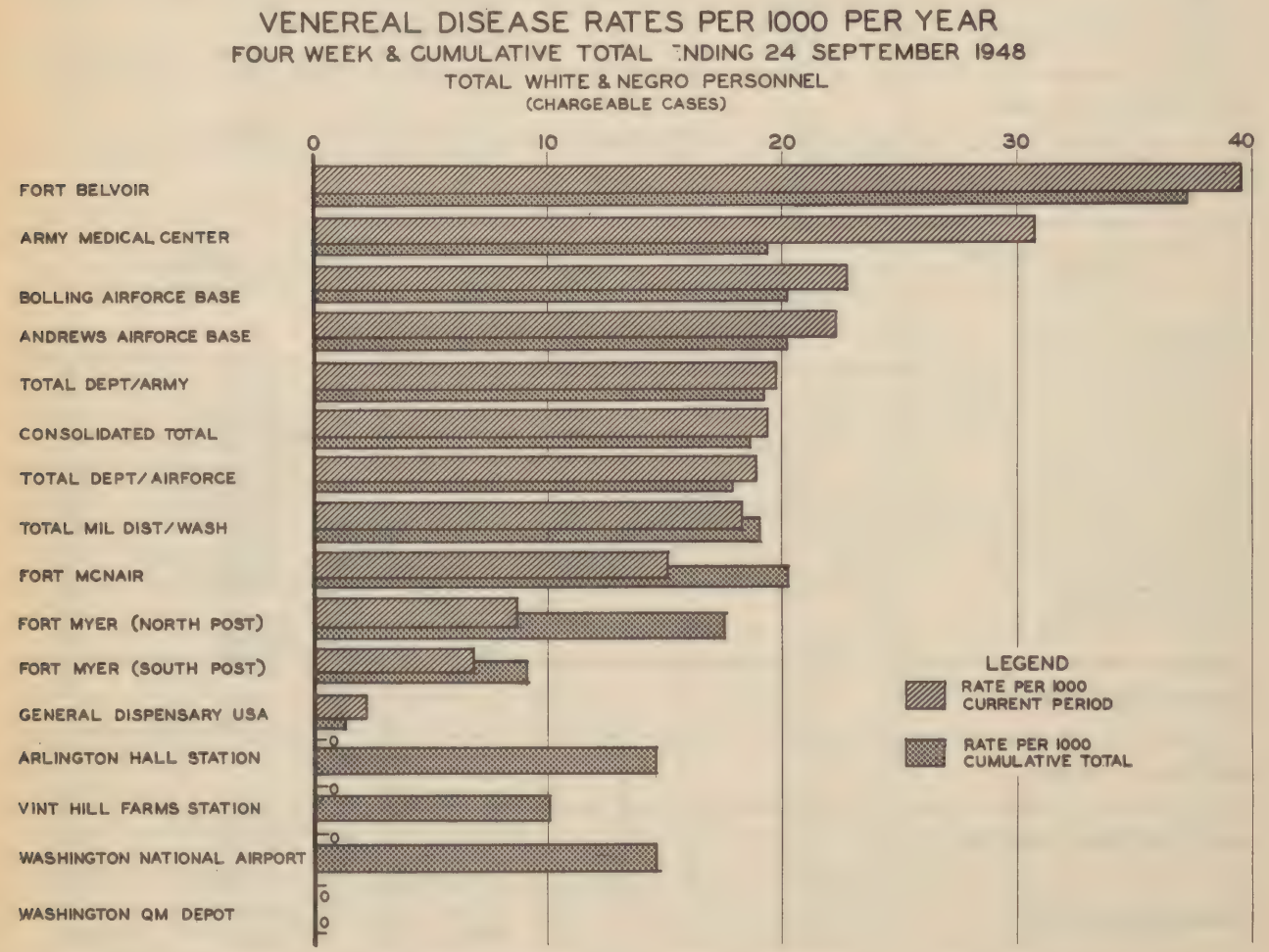
STATION	RACE	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Arlington Hall Station	W	716	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	716	0	0	0	0	-	0
Fort Belvoir	W	6,497	3	13	0	16	32.01	28
	N	1,044	1	6	0	7	87.16	4
	T	7,541	4	19	0	23	39.65	32
Fort McNair	W	762	0	1	0	1	17.06	0
	N	95	0	0	0	0	-	0
	T	857	0	1	0	1	15.17	0
Fort Myer (North Post)	W	1,299	0	1	0	1	10.01	17
	N	165	0	0	0	0	-	0
	T	1,464	0	1	0	1	8.88	17
Fort Myer (South Post)	W	1,873	0	1	0	1	6.94	0
	N	0	0	0	0	0	-	0
	T	1,873	0	1	0	1	6.94	0
General Dispensary, USA	W	5,615	0	1	0	1	2.30	0
	N	27	0	0	0	0	-	0
	T	5,642	0	1	0	1	2.30	0
Vint Hill Farms Station	W	953	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	953	0	0	0	0	-	0
Washington QM Depot	W	9	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	9	0	0	0	0	-	0
Total Mil Dist of Wash	W	17,724	3	17	0	20	14.67	45
	N	1,331	1	6	0	7	68.37	4
	T	19,055	4	23	0	27	18.42	49
Army Medical Center	W	2,219	1	1	0	2	11.72	482
	N	306	1	3	0	4	169.93	179
	T	2,525	2	4	0	6	30.89	661
Total Dept/Army Units	W	19,943	4	18	0	22	14.34	527
	N	1,637	2	9	0	11	87.35	183
	T	21,580	6	27	0	33	19.88	710
CLASS III UNITS Andrews Air Force Base	W	3,390	1	1	0	2	7.67	8
	N	120	1	3	0	4	433.33	16
	T	3,510	2	4	0	6	22.22	24
Bolling Air Force Base	W	5,159	3	6	0	9	22.68	59
	N	0	0	0	0	0	-	0
	T	5,159	3	6	0	9	22.68	59
Wash Nat'l Airport	W	1,579	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	1,579	0	0	0	0	-	0
Total Dept/Air Force Units	W	10,128	4	7	0	11	14.12	67
	N	120	1	3	0	4	433.33	16
	T	10,248	5	10	0	15	19.03	83
Consolidated Total	W	30,071	8	25	0	33	14.27	594
	N	1,757	3	12	0	15	110.98	199
	T	31,828	11	37	0	48	19.61	793

VENEREAL DISEASE RATES FOR THE US *

(All Army Troops)

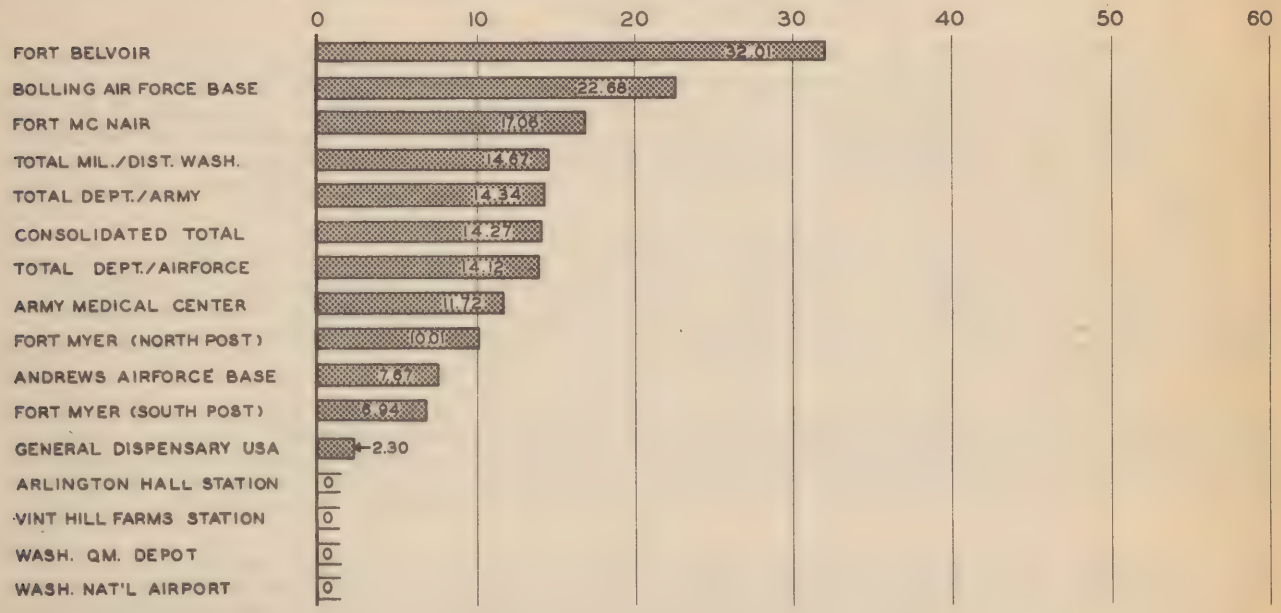
	September	August
First Army Area	28	31
Second Army Area	33	44
Mil District of Washington	20	29
Third Army Area	39	39
Fourth Army Area	33	32
Fifth Army Area	22	27
Sixth Army Area	38	31
Total United States	32	34

* Compiled in the Office of the Surgeon General and includes General Hospitals and Class III installations.



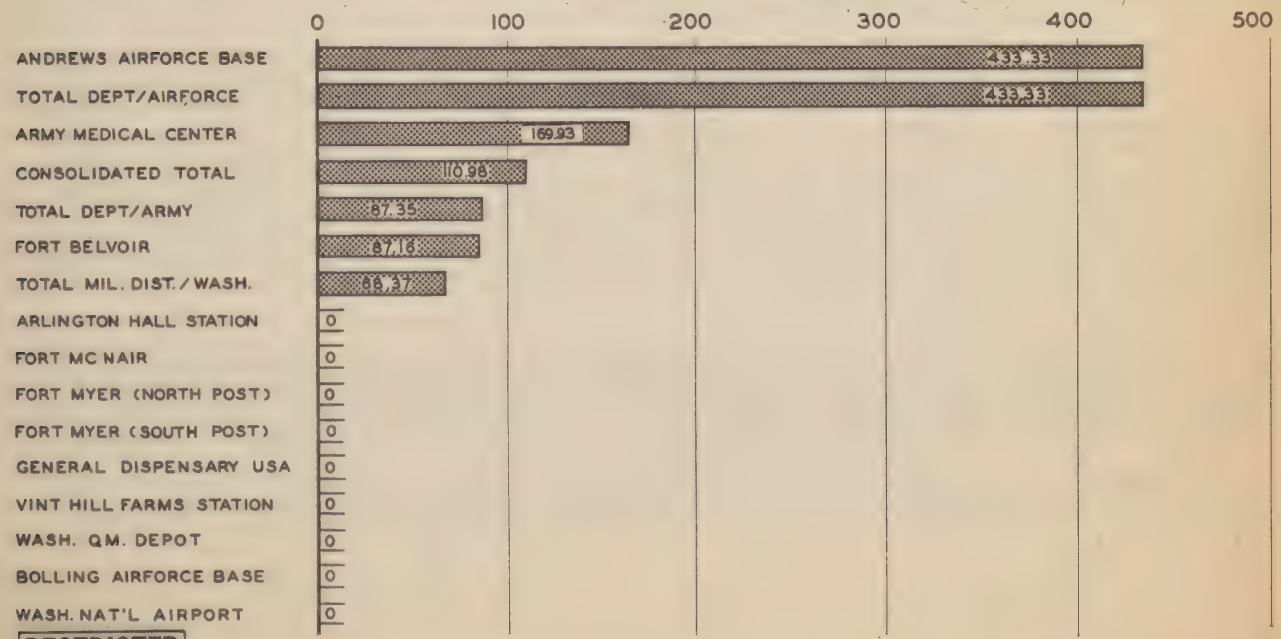
VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR - 4 WEEK PERIOD ENDING 24 SEPTEMBER 1948

WHITE PERSONNEL (CHARGABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR - 4 WEEK PERIOD ENDING 24 SEPTEMBER 1948

NEGRO PERSONNEL (CHARGABLE CASES)



INFLUENZA

Influenza is an acute, highly infectious disease, characterized clinically by sudden onset fever, myalgia, respiratory symptoms; prostration and a tendency toward the development of severe pulmonary complications. The incubation period of influenza is short and variable. It usually lasts from 24 to 48 hours but may be as long as four days.

Influenza is a typical contact disease. It is carried by the infected person and because of its high infectivity it is transmitted by very slight and transient contact. It is probable that the transference of the infection directly from person to person by droplet infection is a most important factor in the transmission of influenza, but transference of the casual agent by inanimate objects and hand to mouth infection also plays an important role in the spread of the disease. Eating utensils and food that has been contaminated with the infective agent are factors in the transmission of influenza.

This disease is probably transmissible throughout its clinical course, but it is generally considered to be most infectious during the period of invasion and the early stages of influenza. The rapid spread of the infection is greatly facilitated by persons who, though they have influenza in a mild form, do not go to bed and are not isolated or segregated, or at least not until the disease is fully developed.

Influenza tends to occur in pandemic cycles consisting of primary and secondary waves. Pandemics and epidemics are characterized by extreme explosiveness and rapidity of spread. A typical epidemic sweeps rapidly through a military organization, the majority of cases occurring within a short time after its introduction. It attacks all ages, but is most fatal in the 20 to 40 year age group. It occurs during all seasons, but most frequently during the colder months of the year.

Pandemic influenza or extensive epidemics of the disease interfere seriously with military operations or the training of troops. The explosiveness of the epidemic and the rapidity with which the infection spreads through a command frequently so cripple an organization that it may, as a whole, become non-effective for the time being. However, the very explosiveness and rapidity of spread also serve to render influenza epidemics short lived, and a military organization recovers from the effect of an epidemic within a comparatively short time.

It is generally considered that an attack of influenza confers only temporary immunity of variable duration, and only to the particular strain of the virus causing the attack. Susceptibility is determined largely by the nonspecific immunity to respiratory infections which may be possessed by the invidual at the time of exposure to infection.

When cases of influenza appear in a command, or when the disease is known to prevail elsewhere and its appearance among the troops is anticipated, all close contact should be reduced to a minimum. The maximum bed space available should be allotted in barracks, and cubicles should be used when practical. In theaters, only alternate seats and rows should be utilized. The troops should be instructed relative to the dangers attendant upon crowding together in day rooms and elsewhere. All close order drill and similar military formations that are not absolutely necessary should be discontinued for the time being. Crowding in mess halls and at the mess tables should be avoided or minimized. Special attention should be given to the thorough disinfection of all mess equipment and eating utensils. Food handlers should be observed and supervised constantly to the end that no individual in the incubationary or early stages of the disease is allowed to contaminate the food or the mess equipment.

Group quarantine is of little or no practical value in the control of influenza. Theaters, service clubs, libraries or other recreational facilities should not be closed except under the most extreme conditions. Measures may be taken to control crowding in these places, but if they are closed the troops will crowd together in other places where they cannot be so readily controlled.

Prompt hospitalization of cases during the early stages of the disease will reduce the opportunities for the dissemination of the infection and will improve the prognosis of the individual case.

INFLUENZA-DIAGNOSIS & TREATMENT

With the advent of cold weather, an increase in the incidence of influenza can be expected, therefore a review of pertinent information concerning the diagnosis, association with penumonia, and treatment of the disease is presented.

Diagnosis

The criteria for the diagnosis of influenza are based on three distinct concepts of the disease, each one of which is important, each one of which serves as a check and a balance upon the others. First, there is the clinical concept. According,to this, influenza is any acute illness of 2-6 days duration, which is not due to any other known agent, and which is characterized by the sudden appearance of fever, muscle aches, headache, mild respiratory symptoms and reddening of face, conjunctivae and throat. Second, there is the epidemiological concept. According to this, influenza is a disease whose distinguishing feature is a habit of appearing periodically in widespread form. These periodic outbreaks are unique in their sudden appearance, their rapid spread across countries and continents, their high attack rate, and their quick subsidence. They are of two types, epidemic and pandemic. Every 1-3 years, epidemics of moderately severe influenza appear which involve 10-20% of the population.[1] Every 30-40 years, pandemics of very severe influenza appear which involve 20-40% of the population.[1] These pandemics are associated with a high percentage of complicating bacterial infections and with a high mortality. The last of these pandemics occurred in 1918-19. Third, there is the etiological concept. According to this, influenza is a disease caused by a specific filtrable virus. This influenza virus was demonstrated first in 1933 by Smith, Andrewes and Laidlaw.[11] Since then it has been shown conclusively to be the cause of epidemic influenza, and of sporadic cases of influenza. However, the relation of this virus to pandemic influenza is undetermined, because there has been no pandemic during the period in which the virus has been known.

Indisputable criteria for the diagnosis of influenza cannot be derived from any one of these concepts. The clinical concept alone is not diagnostic. Included in epidemics are many clinically atypical cases in which influenza virus may be demonstrated.[6,7,9] On the other hand, sporadic cases of disease that entirely fit the clinical concept of influenza may show no evidence of influenza virus.[7,9] Extensive laboratory tests may show that these are due to some other specific agent (for example the spirochaete of Weils Disease or the virus of atypical pneumonia), but more commonly they will give no clue as to the cause of the disease. Certainly, the clinical concept of influenza is not diagnostically specific. Nor is the epidemiological concept, which affords no way of diagnosing the sporadic case of influenza. Finally, the etiological concept does not yield infallible diagnostic criteria. As has been stated the cause of pandemic influenza is as yet undetermined. Even in the case of epidemic influenza, it is believed that the tests used for demonstrating the presence of the virus will miss the virus in many cases. This belief is based on the fact that the tests fail to demonstrate virus in an appreciable number of classical clinical cases of influenza that occur in the midst of typical epidemics of influenza virus infection.[7,9]

A practical set of rules governing the diagnosis of influenza is as follows. Any case fitting the clinical concept of influenza should be considered as being influenza if it occurs during a typical epidemic of proven influenza virus infection. A positive test for influenza virus in such an instance would indicate that the diagnosis was correct. A negative test would not rule influenza out, but would make it less likely. A sporadic case fitting the clinical concept of influenza should be considered as being this disease only if the test for influenza virus is positive.

The easiest method of demonstrating influenza virus is the following. Store in an icebox the serum obtained from 20 cc of venous blood drawn during the first 24 hours of observation of the patient. Ten days later draw from the patient another 20 cc sample of venous blood. Forward to the nearest Army virus laboratory, in separate tubes, the serum obtained from this blood and the stored serum. There the influenza antibody level in the two samples of serum can be determined. The demonstration of a three fold or better rise in antibody level between the first and the second samples indicates the presence of influenza virus infection.

Pneumonia Associated With Influenza

Pneumonia occurs in 5-15% of cases of pandemic influenza.[1] It occurs in only 1-2% of cases

of epidemic influenza.[2,6,7,9] Pneumonia may be present at the onset of disease or it may appear as a later complication. It may be due to the influenza virus alone; much more frequentlyy it is due to secondary bacterial invasion. In reported cases[12] of pneumonia associated with proven influenza virus infection, the pathogenic bacteria have been the Pneumococcus in 26 cases, Staphylococcus Aureus in 19 cases, B. Hemolytic Streptococcus in one case and Hemophilus Influenzae in one case. In two cases of pneumonia associated with proven influenza virus infection, no bacteria could be stained in the lungs or cultured from them at the time of postmortem examination. These two cases have been interpreted as pure influenza virus pneumonia. Pneumonia is the usual cause of death in influenza. Reliable statistics are not yet available on the mortality of influenza associated with bacterial pneumonia that has been treated properly with specific antibacterial agents. Despite the low incidence of pneumonia in epidemic influenza, there is evidence of influenza virus infection in many cases of bacterial pneumonia seen during an influenza epidemic period. 16 out of 36 cases of lobar pneumonia seen on the wards of the Johns Hopkins Hospital during the 1947 influenza A epidemic were proven to have associated infection with influenza virus.[8,12]

Treatment of Influenza

Treatment of influenza should consist of bed rest and medication to relieve symptoms during the period of fever. Careful observation for signs of pneumonia and other complications is indicated. The routine use of specific antibacterial therapy is not warrented, because such treatment has no effect on the virus and is potentially dangerous. The incidence of toxic reactions to penicillin and sulfadiazine is higher than the incidence of pneumonia in most epidemics of influenza. Such specific drugs should be reserved for secondary bacterial infections due to susceptible organisms.

Prophylaxis

The usual general methods for the prevention and control of respiratory disease are indicated. The only specific prophylactic agent is influenza vaccine.

There are at least three different types of influenza viruses. These different types are distinguished by the fact that an immunity to one will not serve as protection against one of the others. These three types have been designated Type A, Type A', and Type B. Influenza vaccine contains a combination of these different types of viruses. Preparation consists of growing the viruses in chicken embryos, killing the virus with an antiseptic, and then combining the different types of viruses to make the vaccine. A single subcutaneous injection of this material into a human being produces within two weeks specific antibodies and immunity to the types of influenza virus injected.[5,6,10] There is evidence that this immunity persists for as long as one year.[10] However, no immunity is produced against types of influenza virus that are different from those contained in the vaccine. This fact was clearly demonstrated in 1947, when a vaccine containing equal parts of Type A and Type B virus -- which had provided protection against the epidemic of influenza A in 1943[2,3,5,6,7,9,10] and against the epidemic of Influenza B in 1945[3], afforded no protection against the epidemic due to Influenza A'.[4] It is suspected that future influenza epidemics may be due to types of influenza virus that are as yet unknown. Therefore, a vaccine containing only the types of influenza virus that are known today is of dubious prophylactic value. For this reason, vaccination of military personnel against influenza during the fall and winter of 1948-1949 will not be carried out as a routine procedure. Evaluation studies are being set up to determine future policy.

1. Blake, F.G., A Textbook of Medicine. Edited by Russel L. Cecil. W.B. Saunders Co., Phila, Pa. 1944, P. 6.
2. Eaton, M.D. and Meiklejohn, G., Amer. Jour. Hyg. 42; 28, 1945.
3. Francis T., Salk., J.E. and Brace, W.M. J.A.M.A. 131; 275, 1946.
4. Francis, T. Jr, Salk J.E., and Quilligan J.J. Jr. Am. J. Pub. Health. 37; 1013, 1947.
5. Hale, W.M. and McKee, A.P. Amer. Jour. Hyg. 42; 21, 1945.
6. Hirst, G.K., Plummer, N., and Friedewald, W.F. Amer. Jour. Hyg. 42; 45, 1945.
7. Magill, T.P., Plummer N., Smillie, W.G., Sugg, J.Y. Amer. Jour Hyg. 42; 94, 1945.
8. Maxwell, E., Van Metre, T.E. Jr, and Ward T. To be published.
9. Salk, J. E., Menke, Wilbur J., Francis, T. Jr. Amer. Jour. Hyg. 42; 57, 1945.
10. Salk, J. E., Pearson, H. E., Brown,P.N.,Smyth,D.J.,Francis,T.Jr. Amer.Jour.Hyg.42; 307, 1945
11. Sigel, M.M., Shaffer, F.W., Henle, W. J. Bact. 54; 277, 1947.
12. Smith, W., Andrewes, C.H., Laidlaw, P.P. Lancet. 2: 66, 1933.
13. Van Metre, T.E. Jr,Maxwell E., and Ward T. To be published.

MALPRACTICE

In order to clarify the status of Army doctors personal malpractice liability, the following information from The Surgeon General's Office, Department of the Army is published for the information of all concerned:

> "It is the opinion of this office, based on opinions of The Judge Advocate General (JAG, 004.6, 1 May 1941; id., 18 Nov 1941), that medical officers are subject to suit for malpractice on negligence and, in event of judgment, there is no means of reimbursement from the Government. Also the individual medical officer must decide for himself whether or not he desires to protect himself from potential malpractice actions against him by liability insurance, the expense of which is the individual's responsibility."

Additional data on this subject appears on page 765 Bulletin of the US Army Medical Department, October 1948, VOL VIII, No. 10, which is quoted in part:

> "*****Information is not available whether there has been a substantial number of successful actions against medical officers based on medical malpractice. Actually it appears doubtful that any member of the military establishment would seek redress from an Army doctor in an action based on medical malpractice, inasmuch as the individual member of the military establishment is protected under the Federal Tort Claims Act. Dependents of military personnel, however, cannot avail themselves of redress under that act, and they may, therefore, sue for malpractice if they choose."

In the United States, its territories and possessions, but not in foreign countries, the Federal Tort Claims Act of 2 August 1946 (60 Stat 842, 28 USC 921) makes provision for claims against the government on account of damage caused by the negligence of Government employees acting within the scope of their employment. Section 403 (d) of said act provides:

> "The acceptance by the claimant of any such award, compromise, or settlement shall be final and conclusive on the claimant, and shall constitute a complete release by the claimant of any claim against the United States and against the employee of the Government whose act or omission gave rise to the claim, by reason of the subject matter."

This provision provided some measure of protection from actions for malpractice of medical officers incident to their military service wherein the United States administratively settles a claim arising out of the same subject matter under the Federal Tort Claims Act, supra. In the event of suit against the United States under the act, it is provided in Section 410 (b) as follows:

> "The judgment in such an action shall constitute a complete bar to any action by the claimant, by reason of the same subject matter, against the employee of the Government whose act or omission gave rise to the claim.*****"

STIMULATING DOSE OF IMMUNIZING AGENTS

The attention of all installations is invited to the contents of Department of the Army Circular 153, Department of the Air Force AFL 160-150, dated 25 May, 1948, concerning administration of stimulating doses of cholera, typhus, plague, Rocky Mountain Spotted Fever, and typhoid-paratyphoid vaccines.

DENTAL SERVICE - MONTH OF SEPTEMBER 1948

STATION	Offi-cers	Days of Duty	Sit-tings	Amal-gam	Oxy-and Amal	Sili-cate	In-lays	Bridges	Bridge Repair	Crown	Dentures			Extrac-tions	Calcu-lus Removed	X-Ray	Examin-ations
											Full	Par-tial	Re-pair				
Arlington Hall Station	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fort Belvoir	3	107	862	52	67	13	0	4	4	0	20	10	6	201	93	105	642
Fort McNair	1	30	620	256	152	32	0	1	5	1	2	9	2	44	39	72	396
Fort Myer (North Post)	2	53	884	127	4	27	0	0	4	1	5	17	16	28	24	464	436
Fort Myer (South Post)	1	52	356	141	43	16	0	0	0	0	1	3	1	36	8	86	172
General Dispensary, USA	4	107	2155	253	47	59	0	7	14	2	11	30	14	124	176	661	537
Vint Hill Farms Station	1	26	955	56	20	33	1	0	0	0	0	4	0	16	0	33	708
Total Mil Dist of Wash	12	375	5832	885	333	170	1	12	27	4	39	73	39	449	340	1421	2891

TOPICALLY APPLIED FLUORIDES

Now that sufficient amount of research and experimentation have proven the value of fluorides in retarding and preventing dental caries, some thought must be given to a simple inexpensive yet practical method of its application.

During the past few years, educational as well as professional societies have found that since such outstanding results have been achieved, they are morally obligated to make a supreme effort to facilitate fluoride treatments to as many as possible.

As could be expected such success has resulted in a whosesale desire by parents to secure treatment for their children. The popularity of this specific treatment is most welcomed by the dental profession not as an income producer but as an index to the parent attitude concerning preventive dentistry. However, a great deal of satisfaction is felt in the profession that at long last we may have a solution to the control of caries.

With this demand for treatment to cope with, the dental surgeon will find it difficult to find the extra time necessary to meet the situation, thereby bringing to our minds the all important question, "Can the fluoride treatment be safely handled by trained assistants and Dental Hygienist"? If so it would not only make possible a wider field of treatment but might in most cases also reduce the cost, thus making it available to more children and the possible use in public schools without the presence of the dental surgeon.

The application of fluorides to the teeth require a few set necessities, which if success is to be had must be rigidly considered.

It is most essential that the preparation be easily applied, one which will not only be of such nature that it can be stored safely, but which will spread evenly to the exposed surfaces of the teeth and be visable on the teeth during the application.

It is also most advantageous that the material adhere to the surfaces of the teeth and yet be of such consistency that it will penetrate all grooves, fissures and irregularaties as well as the interproximal spaces and subgingival area.

With the above prerequisites in mind a paste of the following proportions has been perfected and proven satisfactory.

Sodium Fluoride	3%
Thymol	0.2 parts per hundred
Kaolin)	
Glycerine)	Sufficient to make a paste
Gum Acacia)	
Water)	

This preparation meets the basic requirements of the above topical application of sodium fluorides.

The most common method of applying sodium fluoride is by the use of cotton rolls, hot air blast, and application of the material itself by the use of a brush or wire loop. It is thought that a more satisfactory method could be worked out, which is particularly easy, using the sodium fluoride paste instead of the aqueous solution.

The principal parts of the application technique are listed herewith in the order of their importance:

1. Insist on a complete dental prophylaxis.

2. Take a beeswax impression of both upper and lower teeth, extending the impression to include the gingival margin. Remove and cool.

3. Cut palate from upper impression for comfort.

4. Dry impression and fill with paste to include the crown portion of impression.

5. Dry mouth and insert impression with slight pressure.

6. Keep impression in for 4 minutes under slight pressure.

7. Remove, then rinse mouth with a solution of calcium acetate, made up of 17 grams of calcium acetate to 2 ounces of water. Wash the impression, initial it on the outside and put it away for subsequent treatments of the series.

8. Repeat the process for opposing teeth.

It is believed that this method will be well tolerated by the patient and easy to use, as well as a method which is safe and can be trusted to trained personnel.

(Condensed from a conversation between Dr. Ewing P. Brady, of the LaClede Laboratories and a Dental Officer of the General Dispensary, USA, The Pentagon)

DENTAL CORPS

Army Regulations 40-15, dated 27 September, 1948 establish the Dental Corps as a separate division of the Medical Department, administered by the Chief of the Dental Division, an assistant to the Surgeon General.

Under the provisions of these regulations, a dental officer is designated as a member of the special staff of the commanding officer of a post, camp or station and will be directly responsible to him for matters pertaining to the dental service of the command. Normally this officer will be the senior dental officer and will be designated "Dental Surgeon".

The duties of the Dental Surgeon in addition to his advisory capacity as a staff officer will encompass the professional and administrative functions relative to the operation of the dental service.

Individuals assigned to the Medical Department and who by their qualifications and training have been given a classification peculiar to the dental service will ordinarily be detailed to duties accordingly and will not be used on other duties except in emergency.

VETERINARY HOSPITALIZATION

With the extreme shortage of Veterinary officers in the Army at this time, the treatment of pets of members of the Armed Forces must necessarily be limited. Small animal clinics conducted at these stations is a courtesy service extended to the military personnel by the Post Commanders. In order that small animal services provided by the Veterinary Hospitals of Ft. Myer and Ft. Belvoir to the military personnel stationed within MDW are used efficiently, the following information is published.

Due to the shortage of officers and to the limited time available for such work and the large number of service personnel presently in the Military District, these hospitals can only be operated as out patient clinics. Therefore, no surgery or cases requiring constant medical care can be accepted. Rabies inoculations as required by Army Regulations and local Health Ordinances are provided at these clinics. Immunization against distemper may be obtained. Health Certificates are issued when required. The cost of all medicines and vaccines provided by these clinics will be payed for by the owners of the pets treated.

Clinic hours at Ft. Myer are limited to Thursday afternoon from 1330 to 1630 hours and Saturday from 0830 to 1100 hours. The clinic hours at Ft. Belvoir are from 1400 to 1600 each afternoon, Monday through Friday.

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED SEPTEMBER 1948
(Data obtained from WD AGO Form 8-134)

STATION	* CLASS 3	CLASS 4	CLASS 5	CLASS 6	CLASS 7	CLASS 8	CLASS 9	TOTAL
Fort Lesley J. McNair	-	63,770	71,484	-	135,254	11,297	-	281,805
Fort Belvoir, Virginia	-	327,868	165,933	-	429,533	46,321	-	969,655
Potomac Yards Distribution Plant	-	196,840	110,425	358,497	46,321	- -	-	712,083
Fort Myer, Virginia	-	191,832	189,993	-	325,905	7,171	-	714,901
MDW Vet Det, Fort Myer, Virginia	238,288	-	-	-	-	-	-	238,288
US Navy	289,995	-	-	-	-	-	-	289,995
The Pentagon	-	-	-	-	-	236,974	-	236,974
Total	528,283	780,310	537,835	358,497	937,013	301,763	-	3,443,701
Army Medical Center	-	204,350	49,714	-	254,044	2,784	-	510,892
Washington Quartermaster	-	108,239	56,489	-	196,975	6,946	-	368,649
Andrews Air Force Base	-	74,411	64,262	-	131,165	3,420	-	273,258
Bolling Air Force Base	-	148,378	104,597	-	255,619	30,277	-	538,871
Total	-	535,378	275,062	-	837,803	43,427	-	1,691,670
GRAND TOTAL	528,283	1,315,688	812,897	358,497	1,774,816	345,190	-	5,135,371
REJECTIONS:								
Mil Dist of Washington								
Not Type, Class, or Grade	11,185							11,185
US Navy								
Not Type, Class, or Grade	4,079							4,079
Insanitary or Unsound	648							648
Army Medical Center								
Not Type, Class, or Grade		36						36
Bolling Air Force Base								
Not Type, Class, or Grade		252						252
Fort Belvoir								
Insanitary or Unsound		53						53
Potomac Yards Dist Point								
Insanitary or Unsound		150						150
Washington QM Depot								
Insanitary or Unsound		51						51
Andrews Air Force Base								
Insanitary or Unsound					100	203		303
TOTAL REJECTIONS	15,912	542			100	203		16,757

* Class 3 - Prior to Purchase
Class 4 - On delivery at Purchase
Class 5 - Any Receipt Except Purchase
Class 6 - Prior to Shipment
Class 7 - At Issue or Sale
Class 8 - Purchases by Post Exchange, Clubs, Messes or Post Restaurants
Class 9 - Storage

OUTPATIENT REPORTS

Considerable misunderstanding has existed in the past as to what items should be reported as treatments for Army and Non-Army personnel on WD AGO Form 8-23 (Report of Sick and Wounded).

In order to insure uniformity of items reported and thus enable the Office of the Surgeon, Military District of Washington to use the same yardstick of performance to gauge the amount of medical care given at each Medical Department installation in this command, the following items will be included in reporting treatments in Section 5, WD AGO 8-23.

1. Patient's personal visits to medical officer for professional treatment or care.
2. Consultation services of medical officer furnished personally upon recommendation of a medical officer.
3. House calls made by a medical officer for the care of authorized outpatient personnel.
4. Physical Therapy Treatments.
5. Laboratory procedures completed at the reporting installation for outpatient personnel.
6. Aerosol Therapy.
7. Hypodermic medication (penicillin, etc.) exclusive of immunizations.

Any additional data, as indicated below, may be listed at the direction of the unit surgeon, under "Remarks" in Section 10, WD AGO 8-23:

1. Prescriptions.
2. Dental Treatments.
3. Number of telephone calls requesting professional information or advice of a medical officer by an authorized dependent.

OUTPATIENT SERVICE

Consolidated statistical data on the outpatient service, Military District of Washington, less Walter Reed General Hospital, and Class III installations for the four week period ending 24 September, 1948, are indicated below:

ARMY:
Number of Outpatients.....10,979
Number of Treatments.....13,990

NON ARMY:
Number of Outpatients..... 4,590
Number of Treatments.....10,752

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED..... 1,676

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED.. 6,306

HOSPITAL MESS ADMINISTRATION
(Data from WD AGO Form 8-210)

STATION	June 48	July 48	August 48	September 48
FORT BELVOIR				
Income Per Ration	$ 1.170	$ 1.197	$ 1.267	$ 1.275
Expense Per Ration	1.110	1.180	1.249	1.265
Gain or Loss	+ 0.060	+ 0.017	+ 0.018	+ 0.010
FORT MYER				
Income Per Ration	1.168	1.191	1.213	1.251
Expense Per Ration	1.119	1.223	1.101	1.529
Gain or Loss	+ 0.049	+ 0.032	+ 0.112	- 0.278

TRAINING:

Training Memorandum No 3 Hq, Military District of Washington, dated 27 September 1948, outlines the basic requirements for conduct of training in all T/O and Area Service units within the command.

The following sections which govern training in medical units are quoted for information and guidance of all concerned:

"3. OBJECTIVES

b. Area Service Units: The maintenance of Army-wide standards of discipline, training, military appearance and courtesy among enlisted personnel employed by agencies of the Department of the Army in the Washington area. Necessary basic, technical and "on-the-job" training will be conducted to insure efficient performance of assigned duties.

4. CONDUCT AND SCOPE OF TRAINING

e. Area Service Units:

(1) The training of station complement personnel will consist of not less than three (3) hours per week.

(2) Every effort will be made to improve the military courtesy, conduct, personal appearance and discipline of all military personnel.

(3) Instructions will be conducted in special subjects applicable to the units, as outlined in paragraph 3, above.

f. All units will pay particular attention to leadership training to insure:

(1) The proper exercise of leadership by officers and non-commissioned officers.

(2) The proper training of selected enlisted men as potential non-commissioned officers.

5. SPECIAL INSTRUCTIONS

a. Paragraph 2, Section IX, WD Circular 100, dated 3 April 46, prescribes that one (1) undivided hour per week will be devoted to the Troop Information Program."

CRITERIA GOVERNING PATIENTS ON AIR EVACUATION FLIGHTS.

1. Following message received from Commanding General, Continental Division, Military Air Transport Service, Kelly Air Force Base, Texas, dated 10 September 1948, quoted in SGO Circular 113, dated 24 September is published for information and guidance.

"CNTLD-9M-814

1. Request that all using agencies be notified that the following criteria will govern acceptance of all patients for scheduled Samaritan Air Evacuation Flights:

   a. All patients will be accompanied by clinical records and competent orders except emergencies (emergency being interpreted to mean save life or prevent great suffering).

   b. Psychotic Class 1A patients will be sedated prior to delivery to Flight Line for emplaning and properly restrained where restraining apparatus (JAN MED Catalogue Med Materiel Item No 7-884-010) is available.

   c. Baggage weight is limited to 65 pounds unless orders of patient specifically allow excess amount of baggage in pounds.

2. All air evacuation nurses on scheduled Samaritan flights have instructions to refuse to accept patients not meeting the criteria outlined in Paragraph 1, a, b, and c above.

Following is a list of publications which are of particular interest to the Medical Department:

DEPARTMENT OF THE ARMY CIRCULARS

Cir No	Subject	Date
270	TM 38-505 revised - Shipments of precious metals	2 September 48
273	Fribrin Foam and Thrombin, Human - extension of expiration dates	9 September 48
275	Recruiting for the Regular Army and Regular Air Force	13 September 48
277	Chinaware and Glassware	13 September 48
278	Disposition of Exposed X Ray Films	14 September 48
280	Household Goods	14 September 48
282	AR 55-530 Hospital Ship - rescinded; Officer and Warrant Officer WD AGO 66, certain entries; Requests for Officers by name.	15 September 48
283	Short tours of Active Duty Training for Members of ORC - Certificate in lieu of Physical Examination	16 September 48
293	Efficiency Reports	23 September 48
294	Retiring Boards Terminated at Certain General Hospitals	27 September 48
299	Change - Army Regulations 40-210	28 September 48
300	Voting	29 September 48
302	Supply Bulletin 8-35, 15 August 1946 - rescinded	30 September 48

DEPARTMENT OF THE ARMY MEMORANDA

Memo No	Subject	Date
40-1005-8	Exposed X Ray Film File Questionnaire	14 September 48
145-10-40	Programs for Instruction Dental, Pharmacy and Veterinary Senior ROTC Units	14 September 48
305-15-10 Ch 2	List of Recurring Reports, Authority for Preparation	9 September 48
600-40-1	Wearing of the Winter Service Uniform	1 September 48
600-40-1 Ch 1	Wearing of the Winter Service Uniform	16 September 48
615-500-5	Reception, Allocation and Processing of the Inductee	15 September 48

MILITARY DISTRICT OF WASHINGTON MEMORANDA

Memo No	Subject	Date
44	Visits to the Inspector General	7 September 48
45	Shoes, Low Quarter, Tan	9 September 48
49	Off Limits removal	30 September 48